

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... life
 Hospital, institution, or street address where death occurred:
Washington Co Hospital
 How long in hospital or institution?..... pronounced dead at hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 21 High Street
 (If rural, give LOCATION)
 Is decedent a veteran, name war.....

3. (a) FULL NAME

Albert Larry Bagent

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... SINGLE
 6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... Aug. 16, 1910
 6. (c) If alive, give age..... years
 8. AGE: Years..... 36 Months..... 10 Days..... 14 If less than one day..... hrs. min.

9. Birthplace..... Hagerstown, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Albert Bagent
 13. Birthplace..... Washington Co. Md.
 14. Maiden name..... Susan E. Shank
 15. Birthplace..... Franklin Co. Pa.

16. Informant..... Mr. Albert Bagent
 Address..... 819 Corbett St. Hagerstown, Md.

17. Burial..... Date thereof..... July 3 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... ROSE HILL CEMETERY
 Location..... HAGERSTOWN. MD.

18. Funeral director..... Fred W. Kraiss
 Address..... Hagerstown, Maryland

19. Date rec'd by registrar..... July 3, 1947
 Registrar..... Cliff Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 30, 1947 at 12:40 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....
 and that I last saw him..... alive on..... 19.....

Immediate cause of death..... Acute ventricular fibrillation
 DURATION.....

Due to..... Cerebro-spinal syphilis

Due to.....

Other conditions.....

(Include pregnancy within 5 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results..... Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

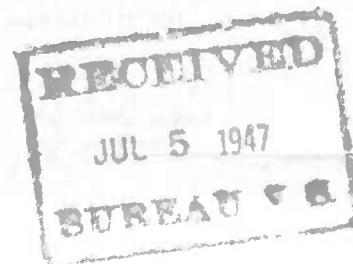
Means of injury..... Injured at work?

DEPUTY MEDICAL EXAMINER.....

23. SIGNATURE..... S. R. Wells WASH. CO., MD.

M. D. WASH. CO., MD.

Address..... Hagerstown, Md. Date signed..... 7/1/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Bell

05347

99

131a

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
817 View St.
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 817 View St.
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war None

3. (a) FULL NAME

John Holland Baltzley

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Emma J. Baltzley
 6.(c) If alive, give age -- years
 7. Birth date of deceased (mo., day, yr.) January 18, 1851
 8. AGE: Years 96 Months 4 Days 19 If less than one day -- hrs. -- min.

9. Birthplace Gettysburg, Adams Co. Pa.
 (Town, county, and state)

10. Usual occupation Engineer

11. Industry or business

12. Name Rev. John Henry Baltzley

13. Birthplace Gettysburg Pa.

14. Maiden name Hannah Donley

15. Birthplace Hunlinton Pa.

16. Informant Ben F. Baltzley

Address Hagerstown Md.

17. Burial Date thereof 6/10/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Kriders Cemetery

Location Westminister Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. June 9, 47 Shacht Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1947 at 11:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1947 to June 7, 1947

and that I last saw him alive on June 7, 1947

Immediate cause of death Cardiovascular renal disease

Due to None

Due to None

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations No operation

Date of op. None

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE Dr. Bell

M. D. or other None

Address Hagerstown Md. Date signed 6/9/47

RECEIVED

JUN 11 1947

BUREAU 68

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this certificate are especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Hoenbaker

93d

05348

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Weeks
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Clearspring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

AARON LUTHER BARTLE

3. (b) Social Security Number

216-22-1847

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Martha E. Mouse
 6.(c) If alive, give age 54 years
 7. Birth date of deceased (mo., day, yr.) Sept. 16, 1872
 8. AGE: Years 74 Months 9 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Clearspring Washington Co., Md.
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business Statton Furniture Co.12. Name James Bartle13. Birthplace Clearspring Md.14. Maiden name Susan James15. Birthplace Clearspring Md.16. Informant Mrs. Glenn ShadrackAddress Hagerstown Md.17. Burial Date thereof 6/27/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Catholic CemeteryLocation Clearspring Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. June 25, 47 Registrar Charles Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 19 47 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/8 19 47 to 6/24 19 47
 and that I last saw him alive on 6/23 19 47

Immediate cause of death acute Coronary Occlusion DURATION 3 days

Due to antecedent Heart Disease with Congestive Heart Failure 1 mo.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John H. Hoenbaker M.D.
154 W. Wash. St. M. D. or other _____Address Hagerstown, Md. Date signed 6/25/47

RECEIVED

JUN 27 1947

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05349

830

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Rural Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 1
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME Heber E. Bohrer
3. (b) Social Security Number 220-10-3576

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Clara V. Bohrer
7. Birth date of deceased (mo., day, yr.) January 25 1899
8. AGE: Years 48 Months 4 Days 29 If less than one day hrs. min.
9. Birthplace Near Berkley Springs W. Va.
(Town, county, and state)
10. Usual occupation Ca rpenter
11. Industry or business Ferguson Co.
12. Name Churchwell E. Bohrer
13. Birthplace Berkley Springs W. Va.
14. Maiden name Icy M. Fernow
15. Birthplace Berkley Springs W. Va.
16. Informant Mrs. Clara V. Bohrer
Address Hagerstown Route 1
17. Burial Date thereof 6-27-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Hagerstown Md.
Location Scott F. Minnich & Son
18. Funeral director Hagerstown Md.
Address
19. June 27, 1947 Chas. H. Powers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH June 24 19 47 at 7:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 19 47 to June 24 19 47
and that I last saw him alive on June 24 19 47
Immediate cause of death Non-traumatic cerebral hemorrhage - from posterior inferior cerebellar artery
DURATION 2 days
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Autopsy results Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide X Date of X
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE W. Howard Dyer
M. D. or other Hagerstown, Md.
Address June 25, 1947
Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 30 1947

BUREAU 66

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

05350

104

Reg. Dist. No. 302

1. PLACE OF DEATH:

County.....Washington
 City or town.....Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Washington
 City or town.....Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....332 South Potomac St.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

James Edward Braungard

3. (b) Social Security Number

None

| | | |
|---|----------------------------------|--|
| 4. Sex <u>Male</u> | 5. Color or race <u>white</u> | 6. (a) Single, married, widowed, or divorced <u>married</u> |
| 6. (b) Name of husband or wife..... <u>Mary C. Braungard</u> | | |
| 7. Birth date of deceased (mo., day, yr.) <u>August 14, 1869</u> | | |
| 8. AGE: Years <u>77</u> | Months <u>9</u> | Days <u>27</u> |
| 6. (c) If alive, give age..... years hrs. min. | | |

9. Birthplace.....Hagerstown, Md.
 (Town, county, and state)
 10. Usual occupation.....Coal Dealer
 11. Industry or business.....

MOTHER
 12. Name.....Jacob Braungard
 13. Birthplace.....Washington Co. Md.
 14. Maiden name.....Almira Hawbaker
 15. Birthplace.....Franklin Co. Penna.

16. Informant.....Mrs. Mary C. Braungard
 Address.....332 S. Potomac St. Hagerstown, Md.

17. Burial.....Burial Date thereof.....June 13, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory.....Rose Hill Cemetery
 Location.....Hagerstown, Md.

18. Funeral director.....Fred W. Kraiss
 Address.....Hagerstown, Md.

19. June 13, 47 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....June 10, 1947 at 11:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

birth to June 10, 1947and that I last saw him alive on June 10, 1947

Immediate cause of death.....

Intermittent Nephritis

DURATION

9 mos.

Due to.....

Due to.....

Other conditions.....

Dissection -

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....None Date of.....Where did injury occur?.....None (City or town) (County) (State)Injured at home, farm, industry, public place (where?).....NoneMeans of injury.....None Injured at work?

23. SIGNATURE.....

Chas. H. Bowers

M. D. or other

Address.....Hagerstown, Md. Date signed.....6/12/47

RECEIVED

JUN 16 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05351

91

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
8 Elizabeth Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 8 Elizabeth Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Clyde E. Brewer

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Virgie J. Brewer
 7. Birth date of deceased (mo., day, yr.) September 29, 1872
 8. AGE: Year 74 Months 8 Day 3 If less than one day
 hr. min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Retired Merchant
 11. Industry or business

FATHER 12. Name Edward L. Brewer
 13. Birthplace Hagerstown, Maryland
 MOTHER 14. Maiden name Emma J. Cook
 15. Birthplace Hagerstown, Maryland

16. Informant Mrs. Thomas D. Dively
 Address Hagerstown, Maryland

17. Burial Date thereof 6-4-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. June 3, 47 Blackbourn
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1 19 47 at 11:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5/30 19 47, to 6/1 19 47
 and that I last saw him alive on 6/1 19 47

Immediate cause of death

Acute respiratory failure

DURATION

2 hours

Due to Ascaris of arch + descending Unknown
arteria & consequent of 1 lung - Several
(antemortem) years
Non-syphilitic at least
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

L. H. St. Homela 2. D.
154 W. Washington St. M. D. or other
Hagerstown, Md. Date signed 6/2/47

RECEIVED

JUN 5 1947

BUREAU VS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

114d

Reg. Dist. No. 302

1. PLACE OF DEATH:
 County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 1/2 years
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospt. Hagerstown, Md.
 How long in hospital or institution? 6 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Washington
 City or town Clearspring R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME WILLARD CANFIELD 3. (b) Social Security Number _____

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary Tedrick Canfield
 6. (c) If alive, give age 19 years
 7. Birth date of deceased (mo., day, yr.) July 11, 1907
 8. AGE: Years 39 Months 11 Days 2 It less than one day _____ hrs. _____ min.
 9. Birthplace Phillippy, W. Va.
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Farmer
 12. Name Unknown
 13. Birthplace W. Va.
 14. Maiden name Unknown
 15. Birthplace W. Va.

MEDICAL CERTIFICATION Dist.
 20. DATE OF DEATH June 10, 1947 19____ at 6:45 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1947 to June 10 1947
 and that I last saw him alive on June 9 1947
 Immediate cause of death Lung abscess Rt. lower and middle lobes DURATION 1 year
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)
 Major findings of operations None Date of op. None
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

16. Informant Wife
 Address Clearspring, Md. R. F. D.
 17. Burial Date thereof June 12, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St Paul Weshm Pike
 Location Weshm Pike
 18. Funeral director Edith D. Deaf
 Address 7 Church Wills and Sub Md
 June 12, 1947 Charles H. Boxer
 (Date rec'd by registrar) Registrar

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Arthur Robert Cohen M. D. or other _____
 Address Clearspring Md Date signed 6-11-47

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The registrar is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 14 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
Hagerstown, Maryland
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 727 South Potomac Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sadie V. Charles

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Harry M. Charles
 6.(c) If alive, give age 72 years
 7. Birth date of deceased (mo., day, yr.) December 25, 1874
 8. AGE: Years 72 Months 5 Days 14 It less than one day _____ hrs. _____ min.

9. Birthplace Marble Valley, Virginia
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name George Rusmiselle13. Birthplace Virginia14. Maiden name Martha Clayton15. Birthplace Virginia16. Informant Harry M. CharlesAddress Hagerstown, Maryland17. Burial Date thereof 6-10-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. June 10, 47 Blas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1947 at H.K.S.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17, 1943 to June 8, 1947and that I last saw him alive on June 8, 1947Immediate cause of death Adenocarcinoma colonColostomy colonDue to Hypertensive Cardiac diseaseDue to Enteritis, Duodenum

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? X X X
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

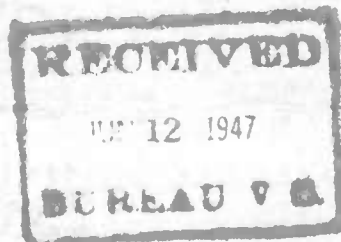
Injured at work?

23. SIGNATURE W. Howard GeorgeAddress Hagerstown, MdDate signed 6-9-47

05353

462

8



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05354

Reg. Dist. No.

302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
7 days
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Fourth and Oak
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William Randolph Colbert

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1879 6.(c) If alive, give age... years

8. AGE: Years 68 Months 6 Days 29 If less than one day
 hrs. min.

9. Birthplace Chambersburg Franklin Pa.
 (Town, county, and state)

10. Usual occupation Laborer11. Industry or business Building12. Name Unknown13. Birthplace II14. Maiden name II15. Birthplace II16. Informant Mrs. Ida ColbertAddress Hagerstown Md.17. Burial Date thereof 6-17-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryHagerstown Md.

Location

16. Funeral director Scott F. Minnich & SonAddress Hagerstown Md.

19. June 16, 47 6:16 AM

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 47 at 6:25a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 47 to June 15, 47and that I last saw him alive on June 15, 47Immediate cause of death Cerebral Embolus DURATION 3 Wks.

Due to

Due to

Other conditions Cortic Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. B. Beachy M.D. or otherAddress Hagerstown Md. Date signed June 16, 47

RECEIVED

JUN 18 1947

BUREAU V.S.

Birth & Death 9

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
City or town Wagons town
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital or institution: Washington County Hospital
Length of mother's stay in County 1 day
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State MD.
County Washington
City or town Wagons town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 234 S. Mallory St.
(If RURAL give LOCATION)

3. Name of child

5. Sex

6. Twin or triplet

4. Date of birth

7. No. of weeks pregnancy

FATHER OF CHILD

8. Full name Harold T. Lederman
9. Color B. 10. Age at time of this birth 27 yrs.
11. Usual occupation Truck Driver

MOTHER OF CHILD

12. Full maiden name Edith Constance Smith
13. Color W. 14. Age at time of this birth 15 yrs.
15. Usual occupation None

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of No

19. Labor: (a) Complications of Breech presentation
(b) Induced? No

20. (a) Was there an operation for delivery? No
(b) State all operations, if any

(c) Did child die before operation? —
During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Placental insufficiency

(b) Maternal causes Breech presentation

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Walter H. Shalby M.D.

(Specify if M. D., midwife, or other)

Address Sharpsburg Md

23. (a) BURIAL (b) Date thereof 6/5/47
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cemetery

24. (a) Funeral director Andrew K. Coffman

(b) Address HAGERS town Md

25. (a) June 5, 1947 (b) Edith Smith
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

Child loved 5 town - 4 8 months

RECEIVED

JUN 7 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

5356

Reg. Dist. No. 315

1. PLACE OF DEATH:

County WashingtonCity or town Breathedsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Md. State Ref. for MadesHow long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 414 South Dallas St

(If rural, give LOCATION)

2. (a) If veteran, name W.W.#2 A.S.N. 33374903 ✓

3. (a) FULL NAME

CLARENCE HENRY DORSEY Jr.

3. (b) Social Security Number

217-09-25694. Sex Male5. Color or race Colored6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife -7. Birth date of deceased (mo., day, yr.) May 23 19108. AGE: Years 36 Months 1 Days 5 If less than one day - hrs. - min. -9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business -12. Name Clarence Dorsey13. Birthplace Baltimore Md.14. Maiden name Louise Dorsey15. Birthplace Baltimore Md.16. Informant Md. State Ref. FilesAddress Breathedsville Md.17. Burial 7/20/47
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Balto Natl CemeteryLocation Baltimore md18. Funeral director ANDREW K CORFMANAddress Hagers town md.19. June 30. 47 John H. Bax
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947 19 47 at 8 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 27 1947and that I last saw him alive on June 27 1947Immediate cause of death Pulm. Tuberculosis

DURATION

6 mos.Due to -Due to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury - Injured at work? -23. SIGNATURE Robert P. Conrad M.D.Address Hagers town Md. Date signed 6-28-47

RECEIVED
JUL 5 1947
BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
 City or town Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind County Washington
 City or town Smithsburg # 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Jacob Elvin Fleagle

3. (b) Social Security Number

173-03-1564

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Bertha Deal

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug 31 1882

8. AGE: Years 64 Months 9 Days 5 If less than one day
 hrs. min.

9. Birthplace Pouersville Pa
 (Town, county, and state)

10. Usual occupation Insolder

11. Industry or business

12. Name Johnson Fleagle

13. Birthplace Ind

14. Maiden name Elizabeth Bush

15. Birthplace Ind

16. Informant Miss Bertha Fleagle

Address Smithsburg Ind # 2

17. Burial Date thereof 6 8 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Harbaugh Cemetery

Location near midwall Pa

18. Funeral director Walter Y Grove

Address Wynnslow Pa

19. June 7 1947 Geo W Ingram
 (Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947 at 1:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-25-47 to 6-6-47

and that I last saw him alive on 6-6-47

Immediate cause of death

Melanoma epithelioma

Due to (Generalized)

Due to Original site

Other conditions undetermined

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

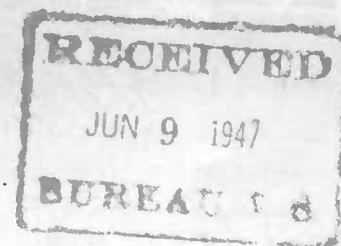
Means of injury Injured at work?

23. SIGNATURE Dr W Ludevan

M. D. or other

Address Wynnslow Pa

Date signed 6/6/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

05358

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 Day
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 451 W. Antietam St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS CLARISSA MORIN FOLTZ

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Samuel E. Foltz
 6.(c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) March 21 1883
 8. AGE: Years 64 Months 2 Days 28 If less than one day - hrs. -- min.

9. Birthplace Hagerstown Washington Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name David H. Morin13. Birthplace Williamsport Md.14. Maiden name Martha E. Summers15. Birthplace Hagerstown Md.16. Informant Samuel E. FoltzAddress Hagerstown Md.17. Burial Date thereof 6/21/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bunkard CemeteryLocation Broadfording Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. June 20 47 Registrar Thos H. Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1947 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-15-47 to 6-19-47
 and that I last saw alive on 6-18-47 1947

Immediate cause of death Cerebral Lesion

DURATION

Due to Stroke

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

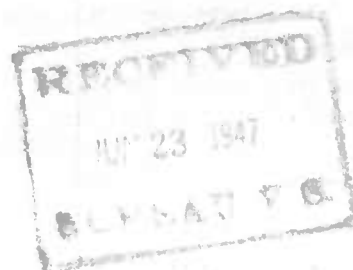
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. DittoAddress Hagerstown Md.Date signed 6/21/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05359

120

1. PLACE OF DEATH:

County Washington CountyCity or town Hagerstown Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Clearspring Md RFD #2
(If outside city or town limits, write RURAL and give nearest town)Street No. Blairsville Valley
(If rural, give LOCATION)2.(a) If veteran, name war None

3.(a) FULL NAME

Grace Louise French

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Harold Ernest French6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.)

Dec. 23 1909

8. AGE:

Years

Months

Days

If less than one day

37528

hrs.

min.

9. Birthplace Williamsport, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

Joseph McCauley

13. Birthplace

Md.

MOTHER

14. Maiden name

Bessie Wolford

15. Birthplace

Maryland16. Informant Harold Ernest FrenchAddress Clearspring Md RFD #217. Burial

(Burial, cremation, or removal. Which?)

Date thereof 6.26.47
(month) (day) (year)Cemetery or crematory Blairsville Valley CemeteryLocation Clearspring Md. RFD #218. Funeral director Edith V. LeafAddress #7 Church St. Williamsport, Md.19. June 24. 47
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947, at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1947 to June 20 1947
and that I last saw him alive on June 20 1947

Immediate cause of death

Acute Cardiac Failure
As Broncho Pneumonia

DURATION

2 days2 days

Due to

Chr. Bronchial Asthma 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David R. Brewer M.D.
Clear Spring Md M. D. or other
Address Clear Spring Md Date signed 6/24/47

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 26 1947

BUREAU C O

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05360

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 years
 Hospital, institution, or street address where death occurred:
37 1/2 North Foundry Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 37 1/2 North Foundry Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Richard R. Gooding

3. (b) Social Security Number

220-10-3871

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Lessie L. Gooding6. (c) If alive, give age 52 years

7. Birth date of

deceased (mo., day, yr.) April 12, 1880

8. AGE:

Years

Months

Days

If less than one day

67

1

25

hrs. min.

9. Birthplace

Washington, D.C.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

12. Name

Gooding

13. Birthplace

Virginia

14. Maiden name

Sallie Hixon

15. Birthplace

Virginia

16. Informant

Mrs. Richard R. Gooding

Address

Hagerstown, Maryland

17. Burial

Date thereof

6-9-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Green Hill Cemetery

Location

Berryville, Virginia

18. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19.

June 8, 47
(Date rec'd by registrar)

Registar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 619. 47at 12:10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

DURATION

Due to Chr. arteriosclerotic
myocardial heart disease

5yrs

Due to coronary occlusion

20hrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results. no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. No

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert Wells

W. CO., MD.

M. D.

Address

Hagerstown, Md.

Date signed

6/7/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 10 1947

BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05361

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
432 N. Jonathan Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 432 N. Jonathan Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

George Edward Hanion

3. (b) Social Security Number

214-10-5703

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Nanny Hanion
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 18, 1874
 8. AGE: Years 73 Months 3 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Falling Waters, W. Va
 (Town, county, and state)
 10. Usual occupation Labor
 11. Industry or business Potomac Edison
 12. Name Alex Hanion
 13. Birthplace Falling Waters W. Va
 14. Maiden name Annie Hayes
 15. Birthplace Falling Waters

16. Informant Mrs. Mary Staley
 Address 432 N. Jonathan Street
 17. Burial Date thereof 6/15/47
 (Burial, cremation, or removal. Which?) (month, day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director William H Downey
 Address 291 Frederick St Hagerstown
 19. June 15, 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

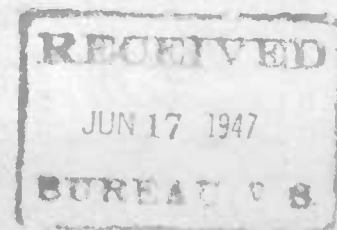
20. DATE OF DEATH June 12 1947 at 11 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 1947 to to same 1947
 and that I last saw him/her alive on June 8 1947
 Immediate cause of death coronary occlusion
 Due to Arteriosclerosis
generalized
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Robert Campbell MD M.D. or other
 Address Hagerstown Md Date signed June 12/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Bell

134

05362

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 1/2 Hours

Hospital, institution, or street address where death occurred:

833 Maryland AveHow long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 833 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

ALTA MARIE HARR

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single6.(b) Name of husband or wife --7. Birth date of deceased (mo., day, yr.) June 30 1947

8. AGE: Years Months Days It less than one day

-- -- -- 7 hrs. 30 min.9. Birthplace Hagerstown, Washington Co. Md.
(Town, county, and state)10. Usual occupation None11. Industry or business --12. Name Thomas M. Harr13. Birthplace Hagerstown Md.14. Maiden name Pearl M. Alger15. Birthplace Shenandoah, Va.16. Informant Thomas M. HarrAddress Hagerstown Md.17. Burial Date thereof 7/1/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 1, 1947 Beaumont Powers,
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1947, at 1:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1947, to June 30, 1947and that I last saw him alive on June 30, 1947Immediate cause of death Prematurity (about 8 hrs. six months)

DURATION

Due to NoneDue to NoneOther conditions None

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury None Injured at work?23. SIGNATURE Ra Bell M. D. Beaumont Powers,Address Hagerstown Md. Date signed 6/30/47

RECEIVED

JUL 3 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

302 Dr. Wells

93d

0536305

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Fairplay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Years

Hospital, institution, or street address where death occurred:

TilghmantonHow long in hospital or institution? --

3. (a) FULL NAME

JOHN HENNESSY

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) October 6, 18816. (c) If alive, give age -- years8. AGE: Years 65 Months 8 Days 18 If less than one day hrs. min.9. Birthplace Tilghmanton, Washington Co., Md.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business --12. Name Peter Hennesy13. Birthplace Ireland14. Maiden name Ellen Dolan15. Birthplace Ireland16. Informant Mrs. Howard HennesyAddress Fairplay Md.17. Burial Date thereof 6/27/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. June 25 19 47 John H. Back
Date rec'd by registrar Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Fairplay

(If outside city or town limits, write RURAL and give nearest town)

Street No. Tilghmanton

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 19 47 at 7 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Jan 1945 to Jan 24 1947and that I last saw him alive on Jan 24 1947Immediate cause of death Heart stopped beat -probably ventricular fibrillationDue to Chronic myocarditis

Dther conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Shealy M.D.Address Hagerstown, Md. Date signed 6/25/47

RECEIVED

JUN 30 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 14 months
 Hospital, institution, or street address where death occurred:
129 W. Church Street
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 129 W. Church Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Leroy C. House

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife... Catherine House

7. Birth date of deceased (mo., day, yr.) April 23, 1890 6. (c) If alive, give age..... years

8. AGE: Years 57 Months 2 Days 2 If less than one day..... hrs. min.

9. Birthplace... Hagerstown, Wash., Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name... Benjamin House
 13. Birthplace... Hagerstown, Md.
 14. Maiden name... Jenny Belt
 15. Birthplace... Frederick, Md.

16. Informant... Mrs. Nellie Williams
 Address... Harrisburg Pa.

17. Burial Date thereof... 6/28/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Rose Hill Cemetery
 Location... Hagerstown, Md.

18. Funeral director... William H. Dunning
 Address... 291 Frederick St. Hagerstown

19. June 28, 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION EDT

20. DATE OF DEATH... June 25 1947, at 1P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... DURATION

acute alcoholic narcosis

chr. arteriosclerotic

coronary heart disease

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results... as above Date of op... June 1947

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... no Date of

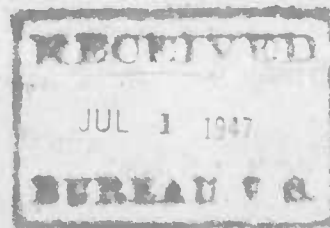
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? MEDICAL

23. SIGNATURE... S. Robert Wells M. D. or other

Address... Hagerstown, Md. Date signed... June 27/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05365

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Clear Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Main St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Samuel N. Hull

3. (b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Clara L. Hull
 7. Birth date of deceased (mo., day, yr.)..... Nov. 23, 1873 6.(c) If alive, give age..... years
 8. AGE: Years..... 73 Months..... 6 Days..... 20 If less than one day..... hrs. min.

9. Birthplace..... Washington County, Md.
 (Town, county, and state)
 10. Usual occupation..... Barber
 11. Industry or business.....

FATHER 12. Name..... Unknown
 13. Birthplace..... Unknown
 MOTHER 14. Maiden name..... Lydia
 15. Birthplace..... Washington County, Md.

16. Informant..... Mrs. Clara L. Hull
 Address..... Clear Spring, Md.
 17. Burial Date thereof..... June 15, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Paul's Cemetery
 Location..... Near Clear Spring Route 40
 18. Funeral director..... Snyder-Rowland Funeral Home
 Address..... Clear Spring, Md.

19. June 16, 1947 (Date rec'd by registrar) Registrar..... Charles Howard

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 12, 1947 19..... 9:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
MAY 26, 1947 19..... to..... JUNE 12, 1947
 and that I last saw h..... alive on..... JUNE 12, 1947 19.....

Immediate cause of death.....
CARDIAC DILATATION, ACUTE DURATION..... 1 HOUR

Due to..... ARTERIOSCLEROTIC HEART DISEASE, WITH HYPERTENSION 1 YEAR

~~XXX~~ ARTERIOSCLEROTIC GANGRENE, RIGHT LOWER EXTREMITY 19 DAYS
 Other conditions.....

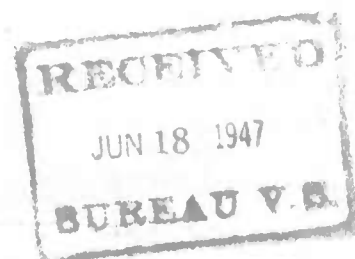
(Include pregnancy within 8 months of death)

Major findings of operations..... ARTERIOSCLEROTIC GANGRENE
 Date of op..... JUNE 12, 1947

Autopsy results..... NONE
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... Arthur Robert Cole M. D. father
 Address..... Clear Spring Md. Date signed..... 6-13-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05366

Reg. Dist. No. 301

1. PLACE OF DEATH:

County WashingtonCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Miller Lumber Company

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 531 Guilford Ave.
(If rural, give LOCATION)2.(a) If veteran, name war 1st & 2nd. World Wars

3. (a) FULL NAME

Jesse Robert Jacobs

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Virginia Jacobs

7. Birth date of

deceased (mo., day, yr.)

Dec. 14, 1898

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

48523

hrs.

min.

9. Birthplace Cearfoss, Wash. Co. Md.
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name William Jacobs13. Birthplace Washington Co. Md.14. Maiden name Lucille Mongan15. Birthplace Washington Co. Md.16. Informant Mrs. Eva MartinAddress 531 Guilford Ave. Hagerstown, Md.17. Burial Date thereof June 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Leaver Creek CemeteryLocation Leaver Creek, Maryland18. Funeral director Fred W. TraissAddress Hagerstown, Md.19. June 8 19 47 Mrs. E. Lee McEroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19 47 at 5:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

DURATION

acute coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

DEPUTY MEDICAL EXAMINER

WASH. CO., MD.23. SIGNATURE J. Robert Wells M. D.Address Hagerstown, Md. Date signed June 7-47

RECEIVED

JUN 11 1947

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Cohen

05367

126

93d

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Week

Hospital, institution, or street address where death occurred:

322 Bryan PlaceHow long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown R # 4
(If outside city or town limits, write RURAL and give nearest town)Street No. Broadfording Road

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM EMORY KRETZER

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Katie

7. Birth date of

deceased (mo., day, yr.)

April 1 1868

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79224

hrs.

min.

9. Birthplace

Boonsboro Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer11. Industry or business Own Farm

FATHER

12. Name

William Krtzezer

13. Birthplace

Boonsboro Md.

MOTHER

14. Maiden name

Maria Duble

15. Birthplace

Boonsboro Md.

16. Informant

Clyde E. Kretzer

Address

Waynesboro PA. R # 2

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6/27/47

(month) (day) (year)

Cemetery or crematory

Dunkard Cemetery

Location

Broadfording Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

June 26, 19 47
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947 19 47 at 11 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 4 19 47 to JUNE 25 19 47and that I last saw him alive on JUNE 24 19 47

Immediate cause of death

ARTERIO SCLEROTIC HEART DISEASE

DURATION

?

Due to

SENILITY?

Due to

Prostatic hypertrophy Benign?

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

NoneDate of op. NO-

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur Robert Cohen

M. D.

Address

Clear Spring MdDate signed 6-26-47

RECEIVED

JUN 28 1947

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

96

05368

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
209 North Mulberry St.
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 209 North Mulberry St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS. EMMA HERMAN LANTZ

3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Harvey C.
 6. (c) If alive, give age -- years
 7. Birth date of deceased (mo., day, yr.) May 17 1874
 8. AGE: Years 73 Months -- Days 30 If less than one day -- hrs. -- min.

9. Birthplace Chewsville Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Henry F. Unger
 13. Birthplace Smithsburg Md.
 14. Maiden name Susan C. Reese
 15. Birthplace Smithsburg Md.

16. Informant Miss Irene Lantz
 Address Hagerstown Md.
 17. Burial 6/10/47
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Smithsburg cemetery
 Location Smithsburg Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. June 8. 47 6 East Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH June 7 1947 19 5 at 5 M

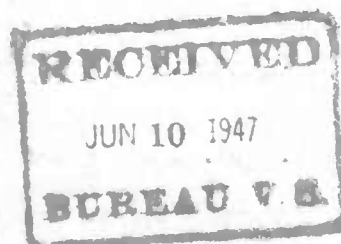
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-47 19 6-7-47 19
 and that I last saw her alive on 6-6-47 19

Immediate cause of death Cerebral thrombosis DURATION 6 min
 Due to Chr. Myocarditis 3 yr
 Other conditions None
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of None
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury None Injured at work?

23. SIGNATURE Dr. Ditto M. D. or other None
 Address Hagerstown Md. Date signed 6/7/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 325

05369

1. PLACE OF DEATH:

County Washington
 City or town Tilghmanton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 51 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Tilghmanton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Helen Leggett

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Nov. 17, 1895
 8. AGE: Years 51 Months 9 Days 24 If less than one day
 hrs. min.

9. Birthplace Tilghmanton-Wash.-Md
 (Town, county, and state)
 10. Usual occupation Home Duties
 11. Industry or business

FATHER 12. Name Jeremiah Mongan
 13. Birthplace Tilghmanton, Md
 MOTHER 14. Maiden name Annie R. Moats
 15. Birthplace Tilghmanton, Md

16. Informant Mrs. Jack Sisk
 Address Tilghmanton, Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 13, 1947
 (month) (day) (year)
 Cemetery or crematory Manor
 Location Tilghmanton, Md

18. Funeral director R. I. Earnshaw
 Address Keedysville, Md

19. June - 12 - 19 47 John W. Best
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 19 47, at 3:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sep. 28, 19 46 to June 10, 19 47
 and that I last saw her alive on June 10, 19 47

Immediate cause of death Cerebral thrombosis
 DURATION 12 hrs.

Due to Vascular syphilis

Due to Syphilis.

Other conditions Aortic regurgitation
Paresis. Tabes dorsalis.
 (Include pregnancy within 3 months of death)
Unknown
1 yr.
plus

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry R. Ellis M.D.
Sharpsburg, Md.
 Address Date signed 6/11/47

9 4 5 9 1 2

RECEIVED

JUN 16 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Lusby

106

93d

05870

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 daysHospital, institution, or street address where death occurred:
Garlock Nursing HomeHow long in hospital or institution? 4 days

3. (a) FULL NAME

Miss Bertha Madden

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single6. (b) Name of husband or wife none7. Birth date of deceased (mo., day, yr.) May 22, 18678. AGE: Years Months Days If less than one day
80 -- 21 hrs. min.9. Birthplace Clear Ridge, Fulton Cty., Pa.
(Town, county, and state)10. Usual occupation Housekeeper11. Industry or business House work12. Name Newton Madden13. Birthplace Maddensville, Pa.14. Maiden name No record15. Birthplace No record16. Informant Merriel G. HenryAddress Kew Gardens, L. I., N. Y.17. Burial Date thereof June 16, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Clear Ridge CemeteryLocation Clear Ridge, Pa.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Md.

June 14, 1947
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna. County FultonCity or town Clear Ridge
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1947 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
8 June 1947 to 13 June 1947
 and that I last saw her alive on 13 June 1947

Immediate cause of death Arterio-sclerotic cardio vascular
Disease

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Lusby M. D. or other

Address 2207 P. Hwy Date signed 14 June 47

Registrar

RECEIVED

JUN 17 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Residential institution, or street address where death occurred:

Route #1, Hancock, Md.How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. High Germany
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (a) FULL NAME

Thomas A. Mann

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Lula Becker Mann6. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) July 8, 18748. AGE: Years 72 Months 11 Days 5 If less than one day — hrs. — min.9. Birthplace Washington Co., Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business —12. Name Denton Mann13. Birthplace Fulton Co., Penna.14. Maiden name Sarah Ann Scott15. Birthplace Allegheny Co., Md.16. Informant Glenn MannAddress Route #1, Hancock, Md.17. Burial Date thereof June 16, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Buck Valley MethodistLocation Buck Valley, Fulton Co., Md.18. Funeral director Charles R. BestAddress Hancock, Md.19. 6-14-47 Registrar J. A. Heller

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1947 at 10:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to June 13, 1947and that I last saw him alive on June 10, 1947Immediate cause of death Chronic myocardial degenerationDURATION 3 mo.Due to —Due to —Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — injured at work?23. SIGNATURE J. A. Watson, M.D.Address Little Orleans, Md. Date signed 6/13/47M. D. or other —

BUREAU V.R.

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Kritzer

05372

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1½ Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1½ Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 111 West Baltimore St
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

FRANK CARR MATTSON

3. (b) Social Security Number

242-03-7564

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Anna
 6. (c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) October 13 1884
 8. AGE: Years 62 Months 8 Days 11 If less than one day
hrs. min.

9. Birthplace Hertzville Bergen Co. New Jersey
 (Town, county, and state)

10. Usual occupation Salesman
 11. Industry or business C.D. Kenney Co.

FATHER 12. Name John Mattson
 13. Birthplace Hertzville N.J.

MOTHER 14. Maiden name Sadie Kircher
 15. Birthplace Camden N.J.

16. Informant Mrs. Anna Mattson
 Address Hagerstown Md.

17. BURIAL Date thereof 6/28/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Ivy Hill Cemetery
 Location Philadelphia Penna.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. June 25, 1947 6 East Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947 19 47 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1947 to June 24 1947
 and that I last saw him alive on June 24 1947
 Immediate cause of death..... DURATION 1 day

Bronchopneumonia
 Due to.....
 Due to.....
 Other conditions Cerebral thrombosis - 1 day
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Henry P. Kritzer M.D. M. D. or other
 Address Hagerstown Md. Date signed 6/25/47

RECEIVED

JUN 27 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05373
301

1. PLACE OF DEATH:

County Washington
 City or town Williamsport
 (If outside city or town limits, write nearest town)
 How long in above place of death? Potomac River (2 days)
 Hospital, institution, or street address, where death occurred:
Potomac River (Drowned)
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington Co
 City or town Williamsport, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Williamsport, Md.
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

Engine Ellsworth Miller

3. (b) Social Security Number

215-26-0916

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife Single
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec. 31 1913
 8. AGE: Years 33 Months 6 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Williamsport, Md.
 (Town, county, and state)
 10. Usual occupation Concrete finisher
 11. Industry or business Sanderson Porter
 12. Name John Eugene Miller
 13. Birthplace Williamsport, Md.
 14. Maiden name Willa Shawn
 15. Birthplace Magnolia W. Va.

16. Informant Mrs. Willa Miller (Mother)
 Address Williamsport, Md.

17. Burial Burial Date thereof June 21 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Riverview Cemetery
 Location Williamsport, Maryland

16. Funeral director Edith V Leaf
 Address #7 Church St. Williamsport, Md.

19. 6-20 19 47 E Lee McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 47 at 4 P M

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

hectatic by
 Due to Drowning
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of 6-17-47
 Where did injury occur Williamsport, Wash. Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Potomac River
 Means of injury Swimming in river Injured at work? no

DEPUTY MEDICAL EXAM.
 23. SIGNATURE Robert Wells WASH. CO., MD.
 Address Hagerstown, Md. Date signed 6-19-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1947

BUREAU OF

Second, death certificate signed
by S. R. Wells, M. D. MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|------------------------------|---|--|---|---|
| 1. PLACE OF DEATH COUNTY Washington County CITY (If outside corporate limits, write RURAL and give nearest town) Highfield TOWN Highfield HOSPITAL OR INSTITUTION OR STREET ADDRESS | | MARYLAND LENGTH OF STAY (In this place) 5 yrs. | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington CITY (If outside corporate limits, write RURAL and give nearest town) Highfield TOWN Highfield STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) Jacob Newton Minnich (First) (Middle) (Last) | | 4. DATE OF DEATH June 3 1947 (Month) (Day) (Year) | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married | 8. DATE OF BIRTH Apr. 22, 1887 | 9. AGE last birthday 60 yrs. | If under 1 year Months. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10b. KIND OF BUSINESS OR INDUSTRY R.R. | 11. BIRTHPLACE (State or foreign country) Waynesboro, Pa | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Jacob Minnich | | 14. MOTHER'S MAIDEN NAME Mary Ruthrauff | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY No. no | | 17. INFORMANT Mrs. Katherine Bowman, highfield | |

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause 331 | | | | (a) Acute cerebral hemorrhage | | | |
| Antecedent cause(s) | | | | (b) _____ | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | | | | (c) _____ | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. MAJOR FINDINGS OF OPERATION --- | | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE No | | (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY m. | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Sudden death , 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 4:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE S. R. Wells M.D. | | (Degree or title) DEPUTY MEDICAL EXAM. | | ADDRESS 115 N. Patomas Hagerstown, Md. | | DATE SIGNED 6/15/49 | |
| 23. BURIAL, CREMATION REMOVAL (Specify) Green Hill Cemetery | | DATE June 5, 1947 | | NAME OF CEMETERY OR CREMATORY Waynesboro, Pa. | | LOCATION (City, town, or county) (State) | |
| DATE REC'D BY LOCAL REG. JUL 11 1947 | | REGISTRAR'S SIGNATURE G.W. Ferguson | | 24. FUNERAL DIRECTOR A.K. Coffman | | ADDRESS 40 E. Antietam St., Hagerstown | |

MARGIN RESERVED, FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

J. 13 1949

JUN 16 1949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Kritzer

05374

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Weeks
 Hospital, institution, or street address where death occurred:
Washington Coty. Hospital
 How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 629 Penna. Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Marie Ella Moore

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Eugene H.
 6.(c) If alive, give age 46 years
 7. Birth date of deceased (mo., day, yr.) Aug. 3, 1898
 8. AGE: Years 48 Months 10 Days 10 If less than one day
 hrs. min.

9. Birthplace Harrisonburg, Va.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Charles L. Smith
 13. Birthplace Cherry Grove, Va.
 14. Maiden name Adaline Gentry
 15. Birthplace Kefeltown, Va.

16. Informant Eugene H. Moore
 Address Hagerstown, Md.
 17. Burial Date thereof June 15, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Bakersville Cemetery
 Location Bakersville, Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown, Md.

19. June 14, 47 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1947 at 3:30 Pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1947 to June 13, 1947
 and that I last saw her alive on June 11, 1947

Immediate cause of death Cardiac Decompensation DURATION 2 yrs.

Due to Cardio-Vascular renal disease

Due to Liver

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. H. Bowers M. D. or other

Address Hagerstown Md. Date signed 6/14/47

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JUN 17 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05375

164C

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
1044 Penna. Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1044 Penna. Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Wayne Harold Moser

3. (b) Social Security Number

214-09-7593

4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Aleiece E. Moser

7. Birth date of deceased (mo., day, yr.) May 22, 1910 8. (c) If alive, give age... years

8. AGE: Years 37 Months 1 Days 0 It less than one day
 hrs. min.

9. Birthplace Brethedsville- Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation Contractor

11. Industry or business

12. Name Harry I. Moser13. Birthplace Frederick County, Md.14. Maiden name Mertie Frey15. Birthplace Frederick, County, Md.16. Informant Mrs. Aleiece E. MoserAddress 1044 Penn. Ave. Hagerstown, Md.

17. Burial Date thereof June 25-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.

19. June 25, 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1947 19 9:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

DURATION

Due to gun shot - woundDue to into chest cavityDue to hemorrhage & shock

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date ofWhere did injury occur? Hagerstown Wash. Md.

(city or town) (County) (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury 12 gauge shot gun Injured at work? no

DEPUTY MEDICAL EXAM.

23. SIGNATURE Dr. Robert Keller WASH. CO., MD.Address Hagerstown, Md. Date signed 6/24/47

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JUN 27 1947

BUREAU 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46B

05376

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

Washington Co. HospitalHow long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Park Head Level
(If outside city or town limits, write RURAL and give nearest town)Park Head Level
(If rural, give LOCATION)

2.(a) If veteran, name war. _____

3. (a) FULL NAME

Cordelia Morrison Munday

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife: Charles E. Munday6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) Nov. 3, 18728. AGE: Years 74 Months 7 Days 25 If less than one day _____ hrs. _____ min.9. Birthplace Washington Co., Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Alec Morrison13. Birthplace Unknown14. Maiden name Rhanna Drury15. Birthplace Franklin Co., Penna.16. Informant Charles E. MundayAddress Big Pool, Route #1, Md.17. Burial Date thereof July 1, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rosehill CemeteryLocation Clearspring, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. June 30, 47 Grasshoppers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 28, 1947 19____ at 4:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DSTAPRIL 15, 1947 19____ to JUNE 28, 1947and that I last saw him ER alive on JUNE 28, 1947 19____

Immediate cause of death _____ DURATION _____

UREMIA _____ ?Due to HYDROPYELONEPHROSIS, BILATERAL _____ ?Due to XXX CARCINOMA OF STOMACH _____ ?

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NONE _____Autopsy results NONE _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Audie Robert Cole M. D. or other _____Address Clearspring, Md. Date signed 6-28-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 2 1947

BUREAU 9 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

930

05377

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Years
 Hospital, institution, or street address where death occurred:
134 Randolph Ave.
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 134 Randolph Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS. LUCY ELLEN MYERS

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
Stokley
 6. (b) Name of husband or wife
 6. (c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) May 30 1875
 8. AGE: Years 72 Months 0 Days 34 It less than one day hrs. min.

9. Birthplace Shenandoah Page Co. Va.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name William Cave
 13. Birthplace Shenandoah Va.
 14. Maiden name Susan Berry
 15. Birthplace Shenandoah Va.

16. Informant Floyd C. Myers
 Address Hagerstown Md.

17. Burial Date thereof 7/17/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. June 17, 1947
 (Date rec'd by registrar) Registrar Health Board

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947 19 8^P at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 - 4, 1947 to June 14, 1947
 and that I last saw her alive on 6-1-47 19 47

Immediate cause of death Chronic Myocarditis DURATION 6 yrs

Due to arteriosclerosis

Due to arteriosclerosis

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations arteriosclerosis Date of op. 6-1-47

Autopsy results arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of June 14, 1947

Where did injury occur? Hagerstown Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Hagerstown Md.

Means of injury Heart Injured at work? None

23. SIGNATURE Dr. Ditto M. D. or other Dr. Ditto

Address Hagerstown Md. Date signed June 17, 1947

RECEIVED

JUN 19 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

05378

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
City or town... Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 9 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 817 Mulberry Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Grace Viola Norris

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife George H. Norris
6.(c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) November 21, 1900
8. AGE: Years 46 Months 6 Days 10 If less than one day hrs. min.

9. Birthplace Frederick, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name Charles Hildebrand
13. Birthplace Frederick, Maryland
14. Maiden name Annie Summers
15. Birthplace Frederick, Maryland

16. Informant George H. Norris, Jr.
Address Hagerstown, Maryland
17. Burial Date thereof 6-3-47
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Rest Haven Cemetery
Location Hagerstown, Maryland
18. Funeral director C.M. Suter & Sons
Address Hagerstown, Maryland
19. June 3, 1947 Charles H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1 19 47 at 130 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-12 19 40 to 6-1 19 47
and that I last saw h. EX alive on 6-1 19 40
Immediate cause of death Carcinoma of Colon (transverse) DURATION 2 yrs. 10 mos.
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings of operations Ca of colon
Date of op. Nov. 1944
Autopsy results on
PHYSICIAN: Please underline the cause to which death should be charged statistically.
transverse Ca of Colon, long, a drual

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE J. L. H. Hildebrand, M.D.
154 W. Washington St. M. D. or other
Address Hagerstown, Md. Date signed 6/2/47

RECEIVED
JUN 5 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05379

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
City or town Breathedsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? From 5/2/46
Hospital, institution, or street address where death occurred:
Md. State Reformatory for Males
How long in hospital or institution? From 5/2/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 251 N. Schroeder St.
(If rural, give LOCATION)
2.(a) If veteran, name war no ✓

3. (a) FULL NAME

CHESLEY CLARENCE PEACE

3. (b) Social Security Number

unknown

4. Sex male 5. Color or race negro 6.(a) Single, married, widowed, or divorced single

8.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/13/30

8. AGE: Years 17 Months 3 Days 23 If less than one day — hrs. — min.

9. Birthplace Oxford, N. C. Granville County
(Town, county, and state)

10. Usual occupation Truck driver

11. Industry or business

12. Name Andrew Peace

13. Birthplace No Record

14. Maiden name Deceased

15. Birthplace ---

16. Informant Md. State Reformatory for Males
Address Breathedsville, Md.

17. Burial Date thereof 6/9/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory State Reformatory Cemetery
Breathedsville Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md

19. June 9, 1947 John H. Best
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1947 at 6:33 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2, 1946 to June 6, 1947

and that I last saw him alive on June 5, 1947

Immediate cause of death Pulm. Tuberculosis

DURATION

35 days

Due to ---

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE Robert P. Conrad M.D.

M. D. or other ---

Address Hagerstown Md Date signed 6-6-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 16 1947

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Kneisley

05380
Reg. Dist. No. 302

1. PLACE OF DEATH:

County... **Washington**
 City or town... **Hagerstown R # 4**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **7 Years**
 Hospital, institution, or street address where death occurred:
Cearfoss Pike
 How long in hospital or institution? **--**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... **Maryland** County... **Washington**
 City or town... **Hagerstown R # 4**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... **Cearfoss Pike**
 (If rural, give LOCATION)
 2.(a) If veteran, name war... **None**

3. (a) FULL NAME

JACOB MARTIN PERROTT

3. (b) Social Security Number

None

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Married**
 6.(b) Name of husband or wife **Effie**
 6.(c) If alive, give age **64** years
 7. Birth date of deceased (mo., day, yr.) **September 30 1879**
 8. AGE: Years **67** Months **8** Days **11** If less than one day
hrs.min.

9. Birthplace **Clear spring Wash. Co. Md.**
 (Town, county, and state)
 10. Usual occupation **Farmer**
 11. Industry or business **Retired**
 12. Name **Alexander Perrott**
 13. Birthplace **Harrisburg Pa.**
 14. Maiden name **Susan Blair**
 15. Birthplace **Welsh Run Pa.**

16. Informant **Mrs. Effie Perrott**
 Address **Hagerstown Md. R # 4**
 17. **Burial** Date thereof **6/18/47**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Dunkard Cemetery**
Broadfording Md.
 Location
 18. Funeral director **Andrew K. Coffman**
 Address **Hagerstown Md.**

19. **June 17. 47** **Blair Bowers**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P20. DATE OF DEATH **June 16 1947** 19 **47** at **1.40** P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **May 1947** to **June 16, 1947**
 and that I last saw him alive on **June 16, 1947**

Immediate cause of death **Hypostatic Pneumonia**
Terminal (of a long illness)
 DURATION **2 days.**

Due to.....

Due to.....

Other conditions **Cerebral Hemorrhage** **2 wks.**
Paralysis Disease **2 yrs.**
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **B. B. Kneisley M.D.****148 W. Wash St. Hagerstown** M.D. or otherAddress: Date signed **6-19-47**

RECEIVED

JUN 19 1947

BUREAU C S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05381

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

2024 Virginia, Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 2024 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

James Hillard Powers, Jr.

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 8, 1945

6.(c) If alive, give age _____ years

8. AGE:

Years

1

Months

11

Days

26

If less than one day

_____ hrs.

_____ min.

9. Birthplace Hagerstown, Wash, Co. Md.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

James H. Powers

13. Birthplace

Hancock, Md.

MOTHER

14. Maiden name

Mildred Clevenger

15. Birthplace

Amarath, Pa.

16. Informant

James H. PowersAddress 2024 Virginia, Ave. Hagerstown, Md.

17.

(Burial, cremation, or removal. Which?)

BurialDate thereof June 5, 1947
(month) (day) (year)

Cemetery or crematory

St. Pauls Cemetery

Location

U.S. Route 40 near Clearspring, Md.

18. Funeral director

Snyder - Rowland

Address

Hancock, Maryland.

19.

(Date rec'd by registrar)

19

June 5, 1947James H. Powers, Jr.

Registrar

MEDICAL CERTIFICATION

E. D. S. T

20. DATE OF DEATH June 3, 1947 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/3/46 to 6/3/47

and that I last saw him on 6/3/47

Immediate cause of death Acute lymphatic leukemia DURATION 6 MO.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Occurred at home, farm, industry, public place (where?) _____

Means of Injury

Injured at work?

23. SIGNATURE

Address William H. Powers, Jr. Date signed 6/4/47

RECEIVED

JUN 7 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington County
 City or town... Hagerstown Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Washington County Hospital Hagerstown

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Williamsport, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Greencastle Pike RFD #2
 (If rural, give LOCATION)
Nhe

2.(a) If veteran, name war.....

3. (a) FULL NAME

Katherine Elizabeth Rickard

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Charles Rickard

6. (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) March 15 1921

8. AGE: Years 26 Months 3 Days 5 If less than one day
 hrs. min.

9. Birthplace Sharpsburg Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Bruce Stevens

13. Birthplace Pa.

MOTHER 14. Maiden name Florence Moats

15. Birthplace Maryland

16. Informant Charles Rickard

Address m Greencastle Pike Williamsport Md

17. Burial Date thereof June 23 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadfording Cemetery

Location Broadfording Road

18. Funeral director Edith V. Leaf

Address #7 Church St. Williamsport, Md

19. June 23, 47 Registrar Charles Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH 6/20/47 19... at SP M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/15/47 to 6/20/47

and that I last saw her alive on 6/20/47 19...

Immediate cause of death Toxemia of pregnancy (Pre Eclampsia) DURATION 5 Days

Due to Pre Eclampsia

Due to Pre Eclampsia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature E. L. Gering M. D. or other

Address Williamsport Md Date signed 6/22/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05382

116

RECEIVED

JUN 25 1947

BUREAU V. O.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

05383

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 40 years
 Hospital, institution, or street address where death occurred:
1138 Potomac Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1138 Potomac Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Kenneth N. Rudisill

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife... Ruth I. Rudisill
 6. (c) If alive, give age... 43 years
 7. Birth date of deceased (mo., day, yr.) June 15, 1902

8. AGE: Years 45 Months 0 Days 5 If less than one day
hrs.min.

9. Birthplace Smithsburg, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation... Proprietor, Clothing Store

11. Industry or business Rudisill & Wolber

FATHER 12. Name George Rudisill
 13. Birthplace Smithsburg, Maryland

MOTHER 14. Maiden name Lydia Miner
 15. Birthplace Smithsburg, Maryland

16. Informant Mrs. Kenneth N. Rudisill
 Address Hagerstown, Maryland

17. Burial Date thereof 6-23-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. June 21, 47 Chas. Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19. 47 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 18 19. 46 to June 20 19. 47
 and that I last saw him alive on June 19 19. 47

Immediate cause of death Cerebral Hemorrhage DURATION 6/20/47

Due to arteriosclerosis
Hypertension

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE H. S. Porterfield M.D. M. D. or other
 Address 136 W Washington Date signed 6/20/47

MARGIN RESERVED FOR BINDING

VS A15

9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1947

BUREAU 58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Victor Miller

05384

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 Years
 Hospital, institution, or street address where death occurred:
24 East Washington St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 24 East Washington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

WILLIAM MCKINLEY SEIGMAN

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced
 6.(b) Name of husband or wife Frances
 6.(c) If alive, give age 52 years
 7. Birth date of deceased (mo., day, yr.) January 12 1900
 8. AGE: Years 47 Months 5 Days 12 If less than one day
 hrs. min.

9. Birthplace Chewsville Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Painter
 11. Industry or business Contractor
 FATHER 12. Name George B? Seigman
 13. Birthplace Cearfoss Md.
 MOTHER 14. Maiden name Emma Bowers
 15. Birthplace Chewsville Md.

16. Informant Mrs. Emma B. Seigman
 Address Hagerstown Md.
 17. Burial Date thereof 6/26/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory U.B. Cemetery
 Location Chewsville Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. June 25, 1947
 (Date rec'd by registrar) Registrar Charles H. Bowers

MEDICAL CERTIFICATION

P

20. DATE OF DEATH June 24 1947 19... at 1.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1947 to June 24, 1947
 and that I last saw him alive on 6/23 19...
 Immediate cause of death Pulmonary Tuberculosis

Due to Pulmonary Tuberculosis
 Due to —
 Other conditions —
 (Include pregnancy within 8 months of death)

Major findings of operations...
 Date of op...
 Autopsy results...
 PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
 Accident, suicide, or homicide...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Victor Miller M. D. or other
 Address 131 W. WASHINGTON, ST. Date signed 6/25/1947
HAGERSTOWN, MD.

RECEIVED

JUN 27 1947

SECRET 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05385

129

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 years
 Hospital, institution, or street address where death occurred:
68 west side Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 68 West Side Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Cyrus J. Shipp

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Belle S. Shipp
 7. Birth date of deceased (mo., day, yr.) May 10, 1867 6. (c) If alive, give age years
 8. AGE: Years 80 Months 1 Days 14 It less than one day
 hrs. min.

9. Birthplace Franklin Co. Penna.
 (Town, county, and state)
 10. Usual occupation Retired Merchant
 11. Industry or business

12. Name Cyrus Shipp
 13. Birthplace Franklin Co. Penna.
 14. Maiden name unknown
 15. Birthplace

16. Informant Mrs. Belle S. Shipp
 Address 68 west Side Ave. Hagerstown, Md.

17. Burial Date thereof June 27, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.

19. June 27 19 47 Paul H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 19 47 at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 47 to June 25 19 47
 and that I last saw him alive on June 24 19 47
 Immediate cause of death

Carcinoma Esophagus

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town) (County) (State)

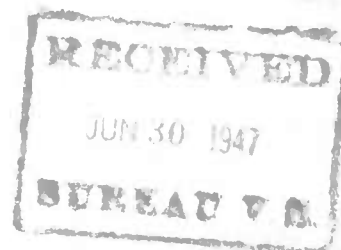
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. B. Porterfield M.D.

M. D. or other

Address 136 W Washington Date signed 6/26/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

87c

05386

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County... Washington
 City or town... Smithsburg Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Washington
 City or town... Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Amos Shockey

3. (b) Social Security Number

4. Sex Male 5. Color or race W. 6. (a) Single, married, widowed, or divorced M.
 6. (b) Name of husband or wife Laura May Barkdoll
 6. (c) If alive, give age 23 years
 7. Birth date of deceased (mo., day, yr.) Dec. 22, 1872
 8. AGE: Years 74 Months 5 Days 27 hrs. min.

9. Birthplace Ringgold Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Benj Shockey
 13. Birthplace Ringgold Md.

MOTHER 14. Maiden name Melinda Kohler
 15. Birthplace Md.

16. Informant Mrs. Laura Shockey
 Address Smithsburg Md.

17. Burial Date thereof 6/21/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Hill
 Location Waynesboro, Pa.

18. Funeral director Walter C. Grove
 Address Waynesboro, Pa.

19. June 20 19 47 Geo W. Ferguson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 19 19 47 at 9 45 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 15 to June - 19 19 47
 and that I last saw him alive on June - 18 19 47
 Immediate cause of death

Coronary Arteriosclerosis DURATION 3 yrs.
 Due to Generalized Atherosclerosis
 Due to Sclerosis DURATION 10 yrs.
 Other conditions Sclerosis
 (Include pregnancy within 5 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Walter H. Dinkins Md. M. D. or other
Waynesboro Pa. Address..... Date signed 6/19/47

RECEIVED

JUN 30 1947

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr/ Victor Miller

132

05387

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 Years
 Hospital, institution, or street address where death occurred:
2409 Virginia Ave
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2409 Virginia Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Martha J. Clark Shoop

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Denton J.
 7. Birth date of deceased (mo., day, yr.) January 8 1870
 8. AGE: Years 77 Months 5 Days 21 If less than one day hrs. min.

9. Birthplace Funkstown Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own home
 12. Name Benj. Clark
 13. Birthplace Funkstown Md.
 14. Maiden name No RECORD
 15. Birthplace " "

16. Informant Mrs. Beulah Paulsgrove
 Address Hagerstown Md. R # 1
 17. Burial Date thereof 7/1/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Dunkard Cemetery
 Location Beaver Creek Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. June 30, 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

P.M

20. DATE OF DEATH June 29 1947 19. 10.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1947 to June 29 1947
 and that I last saw him alive on June 15 1947

Immediate cause of death arterio-sclerosis
chronic - Endo Carditis DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Victor Miller M. D. or otherAddress Hagerstown Md Date signed 1947

RECEIVED

JUL 2 1947

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Kniesly

135

05388

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 14 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 823 W. Washington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Letitia Ann Showe

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife --
 7. Birth date of deceased (mo., day, yr.) June 30, 1947 6.(c) If alive, give age -- years
 8. AGE: Years -- Months -- Days -- If less than one day 14 hrs. -- min.

9. Birthplace Hagerstown, Washington Co. Md.
(Town, county, and state)10. Usual occupation Infant11. Industry or business --

12. Name Richard P. Showe
 13. Birthplace Hagerstown Md.
 14. Maiden name Pauline E. Poffinberger
 15. Birthplace Hagerstown Md.

16. Informant Richard P. ShoweAddress Hagerstown, Md.17. Burial Rest Haven Cemetery Date thereof 7/1/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hagerstown Md.Location Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 1, 1947 Chapman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1947, to June 30 1947
 and that I last saw him alive on June 30 1947
 Immediate cause of death Atelectasis (Pneumonia) DURATION 14 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dr. Kniesly
 Address 148 W. Washington St. Hagerstown Md. Date signed 7/1/47

RECEIVED
JUL 3 1947
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1576

05389

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WASHINGTONCity or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LIFEHospital, institution, or street address where death occurred:
620 L COMMONWEALTH AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTONCity or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)Street No. 620 L COMMONWEALTH AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

TERESA LORRAINE

3. (b) Social Security Number

NONE4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) NOVEMBER 11, 19468. AGE: Years 7 Months 14 Days 14 If less than one day hrs. min.9. Birthplace HAGERSTOWN, WASHINGTON, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name LLOYD BRUCE SHUE13. Birthplace HAGERSTOWN MD.14. Maiden name EVA LORRAINE BARR15. Birthplace HAGERSTOWN, MD.16. Informant Floyd B. Shue (father)Address 620 L Commonwealth Ave.17. Burial Date thereof June 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest HavenLocation Hagerstown Md.18. Funeral director Woodford J. RosmentAddress Hagerstown Md.19. June 26, 47 Phas H. Bowers
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25 19 47 at 7:31 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/13 19 46 to 6/25 19 47
and that I last saw her alive on 6/25 19 47Immediate cause of death Meningitis DURATIONDue to Rupture of meningococciOther conditions None
(Include pregnancy within 3 months of death)Major findings of operations None Date of op.Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE J. H. Bowers M.D. M. D. or otherAddress Hagerstown, Md. Date signed 6/25/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

05390

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
1007 Hamilton Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1007 Hamilton Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Charles Pettis Shufelt

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Edith Shufelt

7. Birth date of deceased (mo., day, yr.) July 20, 1853 6.(c) If alive, give age _____ years

8. AGE: Years 93 Months 11 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Sweetsburg, Quebec, Canada
(Town, county, and state)

10. Usual occupation

11. Industry or business Retired Grocer

FATHER 12. Name Cyrus C. Shufelt

13. Birthplace Orange, New York

MOTHER 14. Maiden name Mary Pettis

15. Birthplace Quebec, Canada

16. Informant Mrs. Matmond A. Spahr

Address 1007 Hamilton, Blvd. Hagerstown,

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 2, 1947
(month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland

July 2, 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1947 19 47 4:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25, 1947 to June 30, 1947
and that I last saw him alive on June 30, 1947

Immediate cause of death Chronic myocarditis
Decomposition
arteriosclerosis
DUE TO

DURATION
1 yr +
15 days
1 yr +

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of X
Where did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

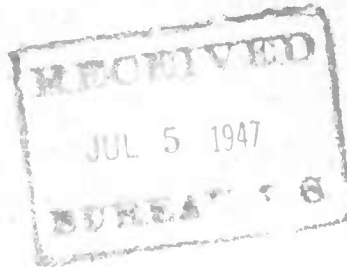
23. SIGNATURE W. Horn Dyeogor M. D. or other

Address Hagerstown, Md Date signed July 1, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The corrected is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Porterfield 77
Dr. Hoenhauer

05391

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 650 Sunset Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

MRS ALICE FULLER SHULL

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Charles Shull

7. Birth date of deceased (mo., day, yr.)

December 22, 1872

6. (c) If alive, give age

80 years

8. AGE:

Years

Months

Days

If less than one day

74

5

14

hrs.

min.

9. Birthplace Hagerstown, Washington Co. Md.
(town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

Jacob Fuller

13. Birthplace

Hagerstown Md.

MOTHER

14. Maiden name

Mary King

15. Birthplace

Hagerstown Md.

16. Informant

Mrs Williard Slifer

Address

Hagerstown Md.

17.

Burial

Date thereof 6/8/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

Date rec'd by registrar

June 8, 19 47

Shast/Bowers

Registrar

MEDICAL CERTIFICATION

R

20. DATE OF DEATH June 6 19 47 at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/5 1947, to 6/6 1947
and that I last saw h. er alive on 6/5 1947

Immediate cause of death

Cerebral thrombosis

DURATION

4 days

Due to

Myocardial infarction - arteriosclerosis
cardiovascular diseaseunknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

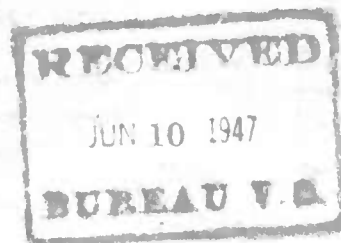
Injured at work?

23. SIGNATURE

John A. Stone

M. D. or other

Address 151 W. Washington St
Hagerstown, Md Date signed 6/6/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05392

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Hagerstown
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 years
 Hospital, institution, or street address where death occurred:
113 C. Carlsow Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 113 C. Carlsow Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Huston Slaughter

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Florence Slaughter
 6.(c) If alive, give age 50 years
 7. Birth date of deceased (mo., day, yr.) March 12, 1895

8. AGE: Years 52 Months 3 Days 3 If less than one day
 hrs. min.

9. Birthplace Lexington, Va.
 (Town, county, and state)
 10. Usual occupation Laborer - Sanitary Commission - Wash., D.C.
 11. Industry or business

12. Name Shops Slaughter
 13. Birthplace Lexington, Va.
 14. Maiden name Amelia James
 15. Birthplace Lexington, Va.

16. Informant Mrs. F. Florence Slaughter
 Address 113 C. Carlsow Ave.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 6/18/47
 (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Md.

18. Funeral director William H. Downey
 Address 291 Fredrick St Hagerstown

19. June 18, 47 Philip C. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947 at 5:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 47 to June 15, 47
 and that I last saw him alive on June 15, 47

Immediate cause of death
Arteriosclerotic heart disease
chronic myocarditis

DURATION
6 hrs.
6 hrs.

Due to
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Philip C. Bowers M. D. or other
 Address 159 W. Washington St. Date signed 6/17/47

RECEIVED

JUN 20 1947

BUREAU OF

05393 93

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington

City or town... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 years

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 2 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 W. Church St.

(If rural, give LOCATION)

2. (a) If veteran, name war...

3. (a) FULL NAME

Daniel Edward Smith

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife... Daisy Ellen Smith

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) April 21, 1878

8. AGE: Years 69 Months 1 Days 12 hrs. min.

9. Birthplace... Bolivar Frederick Md.

(Town, county, and state)

10. Usual occupation... Framer

11. Industry or business... Retired

12. Name... Ephriam Smith

13. Birthplace... Unknown

14. Maiden name... Mary Drench

15. Birthplace... Unknown

16. Informant... Adam Smith

Address... Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-6-47 (month) (day) (year)

Cemetery or crematory... Dunkard Cemetery

Location... Beaver Creek Md.

18. Funeral director... Scott F. Minnich & Son

Address... Hagerstown Md.

19. June 4, 47 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 3, 1947, at 8:25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20, 1947, to June 3, 1947, and that I last saw him alive on June 3, 1947.

Immediate cause of death... Acute Peritonitis

Disease... Acute cholecystitis

DURATION 4 days

Due to... Chronic cholecystitis

DUE TO... 3 yrs

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... B. Prather

M. Dr. or other

Hagerstown Date signed 6/4/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 6 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
 Letter from Charles H. Bowers in permanent file containing reasons for the "Unknown" information entered on certificate.

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... WASHINGTON
 City or town..... HAGERSTOWN
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... North Carolina County..... Cleveland Co.
 City or town..... Ring Mountain
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... W. W. II

3.(a) FULL NAME

Harry Neil Smith

3.(b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Mary Smith
 6.(c) If alive, give age..... Years.....
 7. Birth date of deceased (mo., day, yr.)..... UNK.
 8. AGE: Years..... 26 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... unk.
 (Town, county, and state)
 10. Usual occupation..... unk.
 11. Industry or business..... unk.
 12. Name..... ates Smith
 13. Birthplace..... North Carolina
 14. Maiden name..... Lelia Smith
 15. Birthplace..... North Carolina

16. Informant.....
 Address.....
 17. Burial..... Date thereof..... July 4, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Mt. Rest Cemetery
 Location..... Kings Mountain, North Carolina
 18. Funeral director..... Fred. W. Kraiss
 Address..... Hagerstown, Md.

19. July 1, 1947 Registrar.....
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

1947

20. DATE OF DEATH..... Between June 25 & 28 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....
Fractured skull
Crushed chest, hemorrhage
and shock

Due to.....
 Due to.....
 Other conditions.....

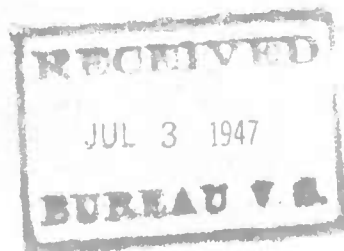
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results..... No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Accident Date of..... Between June 25 & 28
 Where did injury occur?..... Unknown (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)..... In RR car
 Means of injury..... Crushed by shifting lumber in
B.R. car Injured at work?

23. SIGNATURE..... S. Robert Wells DEPUTY MEDICAL EXAMINER
 Address..... Hagerstown, Md. M. D. or other.....
 Date signed..... July 1-47

Letter from Charles H. Bowers in permanent file containg reasons for the "UNKNOWN"
information entered on certificate



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05395
Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years
Hospital, institution, or street address where death occurred:
Washington County Hospital
7 days
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 350 N. Cannon Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William E. Sparrow
3. (b) Social Security Number 220-10-3245

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Anna H. Sparrow
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) October 13, 1876
8. AGE: Year 70 Months 7 Days 23 If less than one day
.....hrs.min.

9. Birthplace Middletown Frederick Md.
(Town, county, and state)
10. Usual occupation Salesman
11. Industry or business P.H.Davis Co.

12. Name Howard E. Sparrow
13. Birthplace Middletown Md.
14. Maiden name Emma J. Corby
15. Birthplace Williamsport Md.

16. Informant Mrs. Anna H. Sparrow
Address Hagerstown Md.

17. Burial Date thereof 6-7-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.

19. June 6, 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1947 at 2:55p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1947, to June 4 1947.
and that I last saw him alive on June 4 1947.

Immediate cause of death
Pneumonia, St.
Due to Carcinoma of prostate
Due to

DURATION
3
7 yrs?

Other conditions Unilateral hearing
stomach failure (cancer)
(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma prostate
unilateral hearing, prostate 1944-1947

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert E. Minnich M. D. or other
Address Hagerstown Md Date signed 6/6/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 9 1947
BUREAU 7 6

DR. PEREGRINE WROTH
HAGERSTOWN, MARYLAND

Explanatory note.

Carcinoma of prostate removed
3 yrs. ago. Bilectome orchidectomy
later.

Strangulated umbilical hernia
peritonitis operated on 3/2/47
with recovery.
Pyonephrosis terminal event.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

Dr. Houghton

05396

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Weeks
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 5 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

JOHN SILVER SPITSNOGLE

3. (b) Social Security Number

717-09. 4185

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Birdie Bohrer
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) October 15, 1880
8. AGE: Years 66 Months 8 Days 5 If less than one day
hrs. min.

9. Birthplace Williamsport Washington Co. Md.
(town, county, and state)10. Usual occupation R.R. Conductor11. Industry or business Retired12. Name Samuel Spitsnogle13. Birthplace Martinsburg W. Va.14. Maiden name Mary Silber15. Birthplace Clearspring Md.16. Informant Mrs. Birdie SpitsnogleAddress Sharpsburg Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/23/47
(month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

June 23, 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1947 at 11:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 13, 1947 to June 20, 1947
and that I last saw him alive on June 20, 1947

Immediate cause of death Typhlophritis
DURATION 1 mo +

Due to Adeno-
Due to Carcinoma of prostate
DURATION 1 yr +

Other conditions Diabetes mellitus
DURATION 20 yr

(Include pregnancy within 8 months of death)

Major findings of operations Sections showed
Carcinoma prostate Date of op. May 20, 47
Autopsy results Typhlophritis, carcinoma prostate
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. L. Houghton M.D. M. D. or other
Address Hagerstown, Md Date signed June 21, 47

RECEIVED
JUN 25 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

05397

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 Days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 21 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R #2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hopewell Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS ANNIE LOUISE STONER

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Luther M 6.(c) If alive, give age 63 years
 7. Birth date of deceased (mo., day, yr.) June 28 1884
 8. AGE: Years 62 Months 11 Days 22 If less than one day hrs. min.
 9. Birthplace Hagerstown Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Charles Metzger
 13. Birthplace Hagerstown Md.
 14. Maiden name No. Record
 15. Birthplace No Record

16. Informant Luther M. Stoner
 Address Hagerstown Md. R # 2
 17. Burial Date thereof 6/23/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven cemetery
 Location Hagerstown Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.
June 23, 1947
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 47, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5-1-47 1947, to 6-20-47 1947
 and that I last saw him alive on 6-20-47 1947

Immediate cause of death Carcinoma Liver
 DURATION 6 mo.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. S. Ditto M. D. or otherAddress Hagerstown Md. Date signed 6/24/47

RECEIVED

JUN 25 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Norment

1612

05398

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 12 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 259 South Potomac St.
 (If rural, give LOCATION)
None
 2. (a) If veteran, name war None

3. (a) FULL NAME

HAROLD DENNIS SWISHER

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife --
 7. Birth date of deceased (mo., day, yr.) June 21 1947
 8. AGE: Years - Months - Days p If less than one day 12 hrs. 27 min.

9. Birthplace Hagerstown Wash. C.o Md.
 (Town, county, and state)
 10. Usual occupation Infant
 11. Industry or business -
 12. Name Harold D. Swisher
 13. Birthplace Greencastle Pa.
 14. Maiden name Jean S. Kisner
 15. Birthplace Big Springs Md.

16. Informant Harold D. Swisher
 Address Hagerstown Md.
 17. Burial 6/23/47
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
St. Pauls Cemetery
 Cemetery or crematory
near Clearspring Md.
 Location
Andrew K. Coffman
 18. Funeral director
 Address Hagerstown Md.

June 23. 19 47
 (Date rec'd by registrar) Registrar B. H. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947 19 47 21 7 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 19 47 to June 21 19 47
 and that I last saw him alive on June 21 19 47

Immediate cause of death Congenital atelectasis
 DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury None Injured at work?23. SIGNATURE Dr. Norment M. D. or otherAddress Hagerstown Md Date signed 6/21/47

RECEIVED

JUN 25 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

175a

CERTIFICATE OF DEATH

Reg. Diat. No.

05399

304

1. PLACE OF DEATH:

County Washington
 City or town Rural - Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 months
 Hospital, institution, or street address where death occurred:
Route #1, Hancock
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Penn. County Fulton Co.
 City or town Rural - Warfordsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Black Oak
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

William Swisher

3. (b) Social Security Number

204-03-5856

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Virginia Bishop Swisher 6. (c) If alive, give age 32 years
 7. Birth date of deceased (mo., day, yr.) March 16, 1906
 8. AGE: Years 41 Months 2 Days 29 hrs. - min. -

9. Birthplace Hancock Wash. Co., Md.
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business -
 12. Name John D. Swisher
 13. Birthplace Fulton Co., Penna.
 14. Maiden name Barbara Spade
 15. Birthplace Fulton Co., Penna.
 16. Informant Blain Swisher
 Address Hagerstown Md.
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 17, 1947
 (month) (day) (year)
 Cemetery or crematory Buck Valley Lutheran
 Location Buck Valley Fulton Co. Penna.
 18. Funeral director Charles R. Bast
 Address Hancock Md.
6/17/47 Registrar J. W. Heller
 Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14 19 47 at 6:15 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 46 to 19 47
 and that I last saw him alive on 6-11 19 47
 Immediate cause of death Fractured spine
 DURATION 8-30-46
 Due to -
 Due to -
 Other conditions -
 (Include pregnancy within 3 months of death)
 Major findings of operations -
 Date of op. -
 Autopsy results -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 8-30-46
 Where did injury occur? Fulton Pa.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Public Road
 Means of injury Wagon turned over Injured at work? yes
 23. SIGNATURE Herbert R. Zohms M.D.
 Address Hancock Md. Date signed 6-16-47
 M. D. or other

RECEIVED
JUN 19 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05400 302

1. PLACE OF DEATH:

County... Washington
City or town... Waguestown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hrs
Hospital, institution, or street address where death occurred:
1216 Virginia Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... MD County... Washington
City or town... Waguestown
(If outside city or town limits, write RURAL and give nearest town)
Street No... 1216 Virginia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Joseph G. Teeter

3. (b) Social Security Number

219-05-0061

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife... Emma

7. Birth date of deceased (mo., day, yr.) August 2, 1867 8.(c) If alive, give age... year

8. AGE: Year 79 Month 10 Day 10 If less than one day... hrs. ... min.

9. Birthplace... Franklin Co, Penna
(Town, county, and state)

10. Usual occupation... Retired Engineer

11. Industry or business

12. Name... John Teeter

13. Birthplace... Penna

14. Maiden name... Catherine Gordon

15. Birthplace... Penna

16. Informant... Mrs. Bertha T. Nichols

Address 1216 Virginia Ave, Waguestown

17. Burial Date thereof June 16, 1947
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory... Fairview Cemetery

Location... Mercersburg, Penna

18. Funeral director... Jacob A. Teeter

Address Greencastle, Penna

19. June 13, 1947 Registrar Charles Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12/47 19... at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/1/47 19... to 6/12/47 19... and that I last saw him alive on 6/12/47 19...

Immediate cause of death... Cancer of Rectum DURATION 1 yr.

Due to... Cancer of Rectum

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Antopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Steffens MD M. D. or other

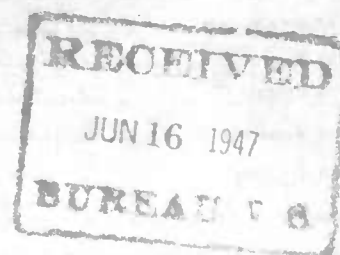
Address Waguestown MD Date signed 6/13/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

05401

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH

County... WashingtonCity or town... Breethedsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

Boonsboro Md. R. 1How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Breethedsville, Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Boonsboro Md. R. 1
(If rural, give LOCATION)2. (a) If veteran, name war no

3. (a) FULL NAME

Ada Arbelin Thomas

3. (b) Social Security Number

- None -

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Earl V. Thomas7. Birth date of deceased (mo., day, yr.) March - 29 - 1885

8. AGE: Years Months Days If less than one day

62 2 29 hrs. min.9. Birthplace near Boonsboro Wash. Co. Md.
(Town, county, and state)10. Usual occupation House wife11. Industry or business own home12. Name Otha J. Shifler13. Birthplace Wash. Co. Md.14. Maiden name Arbelin Douk.15. Birthplace Wash. Co. Md.16. Informant Earl V. ThomasAddress Boonsboro Md. R. 117. Burial Date thereof July 1 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Boonsboro CemeteryLocation Boonsboro Md.18. Funeral director Wm. J. Bast & SonsAddress Boonsboro Md.19. June 30 19. 47 John H. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19. 47, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 6 19. 46, to June 28 19. 47and that I last saw him alive on June 28 19. 47Immediate cause of death Cerebral thrombosisDue to Arteriosclerosis of the ArteriesDue to Arteriosclerosis of the Arteries

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Bast M. D. or otherAddress Boonsboro Md. Date signed 6/30/47

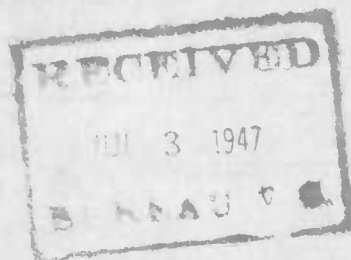
DURATION

20 minutes1 yr. 4 mos. 22 days

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

05402

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Alexander Hotel
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

J. Earlston Thropp Jr.

3. (b) Social Security Number

216-28-0568

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Alice Hart Thropp
 6.(c) If alive, give age 74 years
 7. Birth date of deceased (mo., day, yr.) February 10, 1873
 8. AGE: Years 74 Months 4 Days 16 It less than one day
 hrs. min.

9. Birthplace Conshohocken, Pa.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business Fairchild's Aircraft Division

12. Name Joseph E. Thropp
 13. Birthplace Conshohocken, Pa.
 14. Maiden name Caroline Moorehead
 15. Birthplace Philadelphia, Pa.

16. Informant Mrs. J. E. Thropp Jr
 Address Hagerstown, Maryland
 17. Burial Date thereof 6-28-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. June 29 19 47 G. Kraft Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14, 1945 to June 26, 1947
 and that I last saw him alive on June 25, 1947

Immediate cause of death arteriosclerotic heart
disorder
 Due to decompensation
 Due to acute hypertensive
(essential) cardiac disease
 Other conditions.....

DURATION

4-30-47
4-30-47
45 hours

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

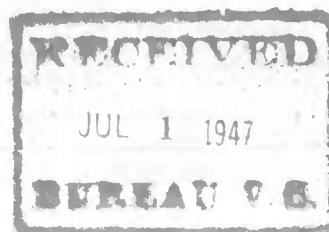
Accident, suicide, or homicide..... Date of.....

Where did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE W. Howard Yeager M. D. or otherAddress Hagerstown, Md Date signed June 27, 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 302

05345

138

1. PLACE OF DEATH:

County WASHINGTONCity or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

UNKNOWN.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE

Years

Months

Days

If less than one day

ABT 26

..... hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

Burial

Date thereof

July 2, 1947

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

BELLEVUE CEMETERY

Location

HAGERSTOWN

18. Funeral director

FRED W. KRAISS

Address

HAGERSTOWN, MD.

19.

July 2, 1947

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Between June 25 & 28, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him alive on..... 19.....

Immediate cause of death

DURATION

Fractured skull

Due to..... crushed chest hemorrhage

Due to..... and shock

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Between June 25 & 28, 1947

Where did injury occur? Unknown (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in RR car

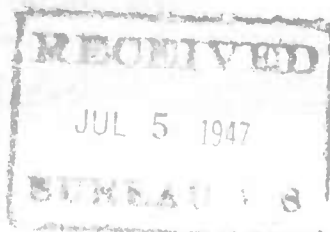
Means of injury crushed by shifting of lumber in RR car

DEPUTY MEDICAL EXAM.

S. Perkins Wells WASH. CO., MD.

23. SIGNATURE M. D. or other

Address Hagerstown, Md. Date signed July 1, 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05443 102

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 weeks
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Rural--Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Earl Martin Wadd

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1941 8. (c) If alive, give age _____ years

8. AGE: Years 6 Months 3 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, -Washington-Maryland
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Leo H. Ward13. Birthplace Flintstone--Maryland14. Maiden name Amy A. Drury15. Birthplace Slyvian-Penna16. Informant Mr. Leo H. WardAddress Keedysville, Md. R.F. D. # 1

17. Burial Date thereof June 11, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Samples-ManorLocation Dargon, Maryland19. Funeral director R. I. EarnshawAddress Keedysville, Md

19. June 10, 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 8 19 47 at 1:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-25 19 47 to 6-8 19 47

and that I last saw him alive on 6-8 19 47

Immediate cause of death Acute glomerular nephritis and Bronchopneumonia

DURATION

Due to _____

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE S. Mayant Prueh M.D.

M. D. or other

Address 135 N. POTOMAC ST Date signed 6-10-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 12 1947

BUREAU 9 &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05404 51

Reg. Dist. No. 304

1. PLACE OF DEATH:

County..... Washington
 City or town..... Rural - Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Hancock (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street..... 5 miles East of Hancock
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Samuel Harrison Weller

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... married
 8. (b) Name of husband or wife..... Mary B. Weller
 8. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... May 5, 1873
 8. AGE: Years..... 74 Months..... 1 Days..... 23 If less than one day..... hrs. min.

9. Birthplace..... Washington Co. Md.
 (Town, county, and state)
 10. Usual occupation..... Farmer
 11. Industry or business.....

MOTHER FATHER
 12. Name..... Charles Weller
 13. Birthplace..... Washington Co. Md.
 14. Maiden name..... Sarah Jane Weller
 15. Birthplace..... Washington Co. Md.

16. Informant..... Mrs Mary B. Weller
 Address..... Hancock, Md.

17. Burial..... Burial Date thereof..... July 1, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Cemetery
 Location..... Shives Cemetery East of Hancock

18. Funeral director..... Snyder-Rowland
 Address..... Hancock, Maryland

19. 7-1-47 19. J. A. Weller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 28 1947 at 5:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1947 to June 28 1947
 and that I last saw him alive on June 27 1947

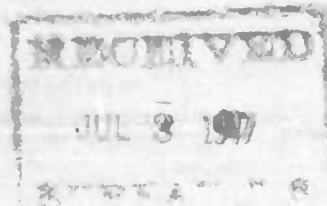
Immediate cause of death..... Central Nervous Age
Arteriosclerosis
 Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... J. A. Weller M. D. or other
 Address..... Hancock, Md. Date signed..... 6/30/47

COPY SENT TO ^{County} ~~LOCAL~~ REGISTRAR No. _____ DATE 7-3-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05405

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
236 Hager St.
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 236 Hager St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS ANNIE ANGLE WINGER

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Clyde E. Winger
 6.(c) If alive, give age 67 years
 7. Birth date of deceased (mo., day, yr.) October 30, 1888
 8. AGE: Years 58 Months 7 Days 7 If less than one day hrs. min.

9. Birthplace Welsh Run, Franklin Co. Pa.
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business Own Home
 12. Name Bery F. Angle
 13. Birthplace Claylick Pa.
 14. Maiden name Lucy Corbett
 15. Birthplace Clearspring Pa.

16. Informant Miss S. Helen Winger
 Address Hagerstown Md.
 17. Burial Date thereof 6/10/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Welsh Run Dunkard Cemetery
 Location Welsh Run Pa.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Date rec'd by registrar June 9, 1947 Registrar Charles A. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1947 to June 7, 1947
 and that I last saw her alive on June 7, 1947

Immediate cause of death Coronary Thrombosis DURATION 1 day

Due to Coronary atherosclerosis 2 yrs.

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles A. Bowers M. D. or other _____

Address 214 N. Potomac St. Date signed June 9, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1947

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Cohen

05406

115

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 4 Days

3. (a) FULL NAME

FRANK CALVIN ZIMMERMAN

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife. ---

7. Birth date of

deceased (mo., day, yr.)

April 3 18776. (c) If alive, give age. - years

8. AGE:

Years

Months

Days

If less than one day

70222

hrs.

min.

9. Birthplace

Hancock Wash/ Co. Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Own Farm

MOTHER FATHER

12. Name

Henry C. Zimmerman

13. Birthplace

Sylvan Pa.

14. Maiden name

Sarah E. Winger

15. Birthplace

Little Cove Pa.

16. Informant

Walter C. Zimmerman

Address

Clear Springs Md.

17.

Burial

Date thereof

6/27/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Methodist cemetery

Location

Little Cove Pa.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md

19.

(Date rec'd by registrar)

June 26 47 Phyllis Powers
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town

Big Spring R # 1

(If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

None

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 25 1947 19 47 at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 20 19 47 to JUNE 25 19 47and that I last saw him alive on JUNE 25 19 47

Immediate cause of death

Hodgkin's Disease

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NoneDate of op. None

Autopsy results

Same.

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. ---Date signed 6-26-47

